SUMMARY OF MATERIAL MODIFICATIONS
To the Summary Plan Description for City of Hialeah
Effective: January 1, 2016
Group Number: 715665

A Summary Plan Description (SPD) was published effective January 1, 2016. The following are modifications and clarifications that are effective January 1, 2016 unless otherwise stated. These modifications and clarifications are intended as a summary to supplement the SPD. It is important that you keep this summary with your SPD since this material plus the SPD comprise your complete SPD.

In the event of any discrepancy between this Summary of Material Modifications (SMM) and the SPD, the provisions of this SMM shall govern.

SECTION 3 – HOW THE PLAN WORKS (Indemnity)

1. **The Plan has modified Section 3, *How the Plan Works*, by replacing the *Eligible Expenses* provision in its entirety as follows (i.e., the Plan added clarification to Eligible Expenses specific to services received from a non-Network provider as a result of an Emergency and for laboratory services or durable medical equipment):**

Eligible Expenses

City of Hialeah has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. Providers may request that you pay all charges when services are rendered. You must file a claim with UnitedHealthcare for reimbursement of Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

Eligible Expenses are based on the following:

- When Covered Health Services are received from a provider that has agreed to participate in a Plan that does not offer a network of participating providers, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.
- Eligible Expenses are determined based on 110 - 200% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:

- 50% of *CMS* for the same or similar laboratory service.
- 45% of *CMS* for the same or similar durable medical equipment, or CMS competitive bid rates.

■ When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:

- For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

- For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*®), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

- When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

UnitedHealthcare updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

■ For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.

■ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS) for Medicare* for the same or similar service within the geographic market.

■ When a rate is not published by *CMS* for the service, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*.

Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

2. The Plan has modified Section 4 and 5, *Plan Highlights*, by adding virtual visits to the *Schedule of Benefits*. Virtual visits are considered a Covered Health Service under the Plan as follows:

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Choice Plus Base and Premier (1 & 2)

Covered Health Services[1]	**Benefit** ***(The Amount Payable by the Plan based on Eligible Expenses)***	
	Network	**Non-Network**
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	100% after you pay a Copayment of $25 per visit	Non-Network Benefits are not available.

Indemnity Base (7)

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*
Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	80% after you meet the Annual Deductible

Indemnity Premier (6)

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*
Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	90% after you meet the Annual Deductible

SECTION 5 & 6 – ADDITIONAL COVERAGE DETAILS

3. **The Plan has modified Section 5 (Indemnity) and 6 (Choice Plus): *Additional Coverage Details* by replacing the Habilitative Services provision in its entirety with the following (i.e., the Plan has adopted the description of Habilitative Services as modified by *The Department of Health and Human Services*):**

Habilitative Services

Benefits for habilitative services are subject to the limits and are provided as stated under *Rehabilitation Services - Outpatient Therapy* in Section 5 (Indemnity) and 6 (Choice Plus),

Additional Coverage Details and *Spinal Treatment* in Section 5 and 6, *Additional Coverage Details* and are subject to the requirements stated below.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Plan may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this Benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

4. The Plan has modified Section 5 (Indemnity) and 6 (Choice Plus), *Additional Coverage Details*, to add a Benefit for virtual visits that are considered a Covered Health Service under the Plan as follows:

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email or fax, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

SECTION 7 – RESOURCES TO HELP YOU STAY HEALTHY

5. The Plan has modified Section 7, *Resources To Help You Stay Healthy* , by replacing the *Health Assessment* provision in its entirety as follows:

Health Survey

You and your Spouse are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page. If you need any assistance with the online survey, please call the number on the back of your ID card.

SECTION 8 – EXCLUSIONS AND LIMITATIONS

6. The Plan has modified Section 8, *Exclusions and Limitations* by replacing the exclusions for *Drugs and Mental Health/Substance Use Disorder* in their entirety as follows:

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 14 (Indemnity) and 15 (Choice Plus), *Outpatient Prescription Drugs*, for coverage details and exclusions.

1. Prescription Drug Products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting).

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

1. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.
2. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
3. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
4. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

Mental Health/Substance Use Disorder

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorder - Autism Spectrum Disorder Services* and/or *Substance Use Disorder Services* in Section 5 (Indemnity) and 6 (Choice Plus), *Additional Coverage Details*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   - Not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time.
   - Not clinically appropriate for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

3. Health services or supplies that do not meet the definition of a Covered Health Service – see the definition in Section 13 (Indemnity) or 14 (Choice Plus), *Glossary*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which UnitedHealthcare determines to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this Plan under Section 5, *Plan Highlights* and Section 6, *Additional Coverage Details*.
   - Not otherwise excluded in this Plan under Section 7 (Indemnity) and 8 (Choice Plus), *Exclusions and Limitations*.

4. Mental Health Services as treatments for R, T and Z code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
5. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, sexual dysfunctions, communication disorders, motor disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.
6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
7. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
8. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
9. Intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
11. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
12. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
13. Gambling disorders.
14. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
15. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

SECTION 12 – WHEN COVERAGE ENDS

7. The Plan has modified Section 11 (Indemnity and 12 (Choice Plus), *When Coverage Ends*, by replacing the *When COBRA Ends* provision in its entirety with the following:

When COBRA Ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- The date coverage ends for failure to make the first required premium (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

SECTION 13 (Indemnity) and 14 (Choice Plus) – GLOSSARY

8. The Plan has modified Section 13 (Indemnity) and 14 (Choice Plus), *Glossary*, to remove the defined term "Certificate of Creditable Coverage" (CoCC) and definition in its entirety as follows (i.e., the Affordable Care Act (ACA) requirement to eliminate pre-existing conditions provision is now fully implemented; therefore the need to issue a CoCC has been eliminated):

Remove the term and definition for **Certificate of Creditable Coverage**: A document furnished by a group health plan or a health insurance company that shows the amount of time the individual has had coverage. This document was used to reduce or eliminate the length of time a preexisting condition exclusion applies.

9. The Plan has modified Section 13 (Indemnity) and 14 (Choice Plus), *Glossary*, to add the defined term "Designated Virtual Network Provider" and definition as follows (i.e., the defined term is used in the provision describing the new Benefit for Virtual Visits):

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on

UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

SECTION 14 and 15 – OUTPATIENT PRESCRIPTION DRUGS

10. The Plan has modified Section 14 (Indemnity and 15 (Choice Plus), *Outpatient Prescription Drugs*, by revising exclusion to include prescription medical food products, andto add a new exclusion for dental products as follows:

Exclusions – What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 7 (Indemnity) and 8 (Choice Plus), *Exclusions* also apply to this section. In addition, the exclusions listed below apply.

34 Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.

35. Dental products, including but not limited to prescription fluoride topicals.

SECTION 15 and 16 – IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

11. The Plan has modified Section [15][16], *Important Administrative Information: ERISA*, to replace the *Your ERISA Rights* provision in its entirety with the following (i.e., the Affordable Care Act (ACA) requirement to eliminate pre-existing conditions provision is now fully implemented therefore the need to issue a Certificate of Creditable Coverage has been eliminated):

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under *ERISA*. *ERISA* provides that all Plan participants shall be permitted to:

- Receive information about Plan Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents—including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may

have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 8 and 9, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U.S. Department of Labor*, listed in your telephone directory, or write to the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue NW Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the *Employee Benefits Security Administration* at 1-866-444-3272.

The Plan's Benefits are administered by City of Hialeah, the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and City of Hialeah are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network provider from a provider. UnitedHealthcare and City of Hialeah are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers you receive from providers.

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